**PATIENT INFORMATION AND MEDICAL HISTORY**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies (medication, environmental, metals, animals, substances): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current/Recent medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? **Y or N** Are you breastfeeding? **Y or N**

Do you smoke? Currently? **Y or N** In the past? **Y or N** How many cigarettes/day? \_\_\_

**Please check if you have or have ever had:**

Diabetes \_\_\_\_\_\_\_\_\_\_\_ Irregular menses \_\_\_\_\_\_\_\_\_

Hepatitis \_\_\_\_\_\_\_\_\_\_\_ Heart problems \_\_\_\_\_\_\_\_\_

Herpes \_\_\_\_\_\_\_\_\_\_\_ Hysterectomy \_\_\_\_\_\_\_\_\_

Menopause \_\_\_\_\_\_\_\_\_\_\_ Hypertension \_\_\_\_\_\_\_\_\_

Sensitive to anesthetic \_\_\_\_\_\_\_\_\_\_\_ Photosensitive Disorder \_\_\_\_\_\_\_\_\_

Lupus \_\_\_\_\_\_\_\_\_\_\_ Autoimmune Illness \_\_\_\_\_\_\_\_\_

Myasthenia Gravis \_\_\_\_\_\_\_\_\_\_\_ Thyroid Disorders \_\_\_\_\_\_\_\_\_

Cold Sores/Herpes \_\_\_\_\_\_\_\_\_\_\_\_ Pancreatitis \_\_\_\_\_\_\_\_\_

Are you currently receiving treatments for any of the above conditions? ­­­

Any Other Medical Illness/conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had the Covid-19 Vaccine? \_\_\_YES \_\_\_\_NO Date of last Covid-19 vaccination\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us? Google Search Rewards Program Provider Search**

 **Referral Who can we thank for the referral?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle if you have or have ever had: IF YES, EXPLAIN**

Keloid scars ­ Yes No Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hives Yes No Cause, if known\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Cancer Yes No Type/Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Waxing Yes No Last Treatment Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Electrolysis Yes No Last Treatment Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cold Sores Yes No Last Outbreak \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypersensitivity to skin products Yes No Name of Product \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Infections Yes No Date/Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tanning within the last 6 wks Yes No Last Treatment Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of acne products/drugs Yes No Last Treatment Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laser skin resurfacing Yes No Last Treatment Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chemical Peels Yes No Last Treatment Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of Photo sensitizing substances Yes No Name of Substance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laser work of any type Yes No Last Treatment Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Aesthetic Procedures of Interest:**

**Chemical Peel \_\_\_\_\_\_\_\_\_\_\_\_\_ Microneedling ­­­\_\_\_\_\_\_\_\_\_\_\_\_ Microneedling with PRP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Neurotoxin Injections (Botox, Xeomin, Dysport, Jeuveau)** **Filler**

Frown lines (between the eyes) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lip Augmentation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Horizontal forehead lines\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nasolabial folds \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crow’s Feet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marionette Lines\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bunny lines (bridge of nose) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vertical lip lines\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Droopy Eyebrow \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scar fill-in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.**

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_